STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005051	A. BUILDING: _____ B. WING _____	09/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH	1701 N SENATE BLVD INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for a State hospital complaint survey. Complaint Number: IN00134495 Unsubstantiated and no citation Facility Number: 005051 Survey Date: 9-16-13 Surveyor: Jack I. Cohen, MHA Medical Surveyor Indiana University Health is in compliance with Hospital Licensure Rules 410 IAC 15-1.6-4, Outpatient care services and 410 IAC 15-1.6-6, Rehabilitation services. QA: claughlin 10/15/13	S 000		